August 13, 2003

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-03-1289-01-SS

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). ___' IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ___ for independent review in accordance with this Rule.

___ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing physician on the ___ external review panel. This physician is board certified in neurosurgery. The ___ physician reviewer signed a statement certifying that no known conflicts of interest exist between this physician and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ___ for independent review. In addition, the ___ physician reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 52 year-old female who sustained a work related injury on ___. The patient reported that while at work a large case of liquid cooking oil fell onto her causing injury to her neck and right shoulder, arm forearm and hand. The diagnoses for this patient include right shoulder strain, cervical strain and lumbar strain. The patient underwent an orthopedic evaluation that indicated the patient had right shoulder impingement and a possible cervical herniated nucleus pulposus. The patient underwent two cervical MRI, a CT scan of the cervical spine, MRI and CT scans of her right shoulder and a cervical discography.

Requested Services

Anterior Cervical Microdiscectomy and Fusion at C3-4 and C4-5.

Decision

The Carrier's denial of authorization for the requested services is upheld.

Rationale/Basis for Decision

The ___ physician reviewer noted that this case concerns a 52 year-old female who sustained a work related injury to her neck and right shoulder, arm, forearm and hand. The ___ physician reviewer also noted that the diagnoses for this patient included right shoulder strain, cervical strain and lumbar strain. The ___ physician reviewer further noted that the patient has undergone two cervical MRIs, a CT scan of the cervical spine, MRI and CT scans of the right shoulder and a cervical discography. The ___ physician reviewer explained that the documentation does not support a reasonable indication for cervical

microdiscectomy for this patient. The ___ physician reviewer explained that the data on discectomy for treatment of purely discogenic pain, is not indicative of clinical success with this algorithm. Therefore, the ___ physician consultant concluded that the requested anterior cervical microdiscectomy and fusion at the C3-4 and C4-5 levels is not medically necessary to treat this patient's condition.

This decision is deemed to be a TWCC Decision and Order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **10 (ten)** days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **20 (twenty)** days of your receipt of this decision. (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed. (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing should be sent to:

Chief Clerk of Proceedings
Texas Workers' Compensation Commission
P.O. Box 40669
Austin, TX 78704-0012

A copy of this decision should be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute. (Commission Rule 133.308(t)(2)).

Sincerely,

I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 13th day of August 2003.